C+D

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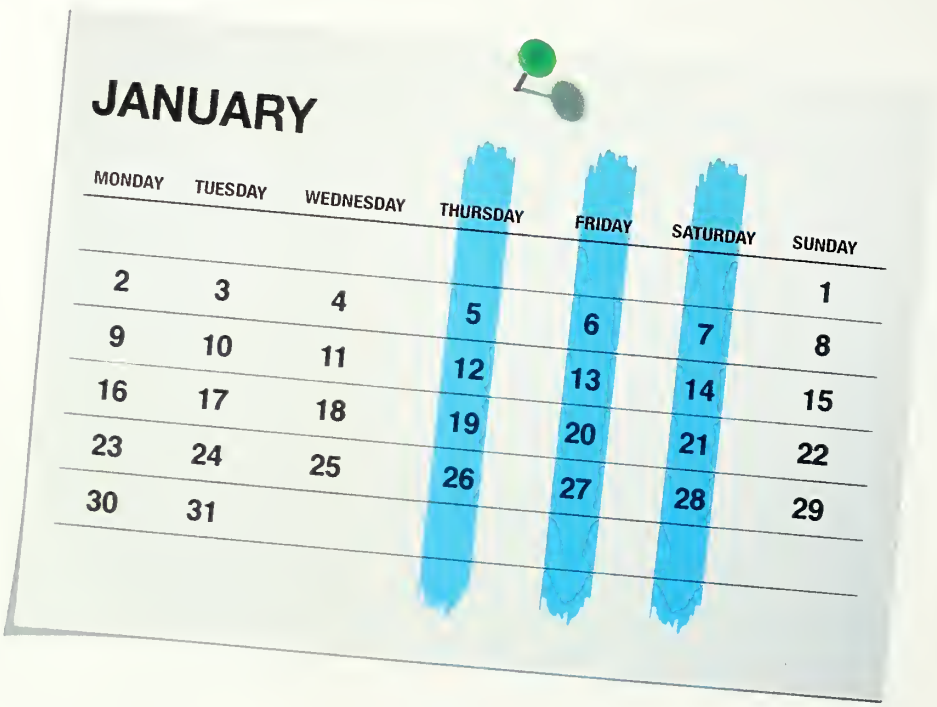
30 January 2010


# Has the pandemic peaked?

## Why you must not let your guard down

Analysis: see page 8

**PLUS**



**Group Editor**
Gary Paragpuri MRPharmS
01732 377688
**News Editor**
Max Gosney 01732 377315
**Features Editor**
Jennifer Richardson 01732 377088
**Digital Content Editor**
Niall Hunt 01732 377284
**Reporters**
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Fay Jones 01732 377396
**Group Art Editor**
Richard Coombs 01732 377528
**Designers**
David Farram 01732 377120
Jo Konopelko 01732 377231
**Office Manager**
Elaine Steele 01732 377621
(fax): 01732 367065
elaine.steele@ubm.com
**Marketing Manager**
Emily Miles 01732 377612
**Commercial Director**
Ruth McKay 020 7921 8456
**Advertisement Managers**
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**Online Support Operative**
Jonathan Franklin 020 7921 8333
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020 7921 8667
Darren Larkin (Electronic Data Controller) 020 7921 8294
Sandra Drawbridge (Input Clerk)
020 7921 8674
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01732 377296
**Training Development Managers**
Sara Mudhar MRPharmS
01732 377463
Kinna McConochie MRPharmS
01732 377487
**Projects Administrator**
Pauline Sanderson 01732 377269
**Production Controller**
Christine Langford 0207 560 4133
**Managing Director**
Phil Johnson 01732 377633
**Email**
firstname.surname
@ubm.com

PDA ABC

**Circulation and subscriptions**
**01858 438809**

## Editor's comment

> WHAT IT TAKES TO GET MEMBERS TO ENGAGE WITH THEIR NEW LEADERSHIP BODY IS A GREATER FOCUS ON THE ISSUES THAT DIRECTLY AFFECT THEIR DAILY LIVES

Even Alastair Campbell at his best would have had trouble putting a positive spin on the latest Royal Pharmaceutical Society elections.

With some 80 per cent of members not bothering to cast a vote, you have to wonder just what it takes to stir the average pharmacist to put a handful of crosses against a few names.

And especially against the backdrop of an extensive public relations push over the past year, Lambeth must be scratching its head wondering what else it needs to do to engage the masses.

For the Pharmacists' Defence Association however, the election has been a resounding success. All 11 of the candidates who stood on the PDA's remote supervision ticket swept to victory, polling a significant share of the votes in the process (page 4).

Its stance on remote supervision clearly struck a chord with pharmacists still coming to terms with the responsible pharmacist regulations. And that the PDA-backed candidates won so convincingly does at least show us what it takes to get members to engage with their new leadership body – a greater focus on the issues that directly affect their daily lives.

This is not to say that the PLB's support and leadership functions aren't important, but when you're dispensing hundreds of scripts, counselling patients and delivering medication reviews, you want to know that your leadership body is focused on the challenges that you're having to deal with.

With the search for a new chief executive ongoing (page 4), it would appear the Society still has more to do to demonstrate to the majority just how the new leadership body will serve its members.

At a branch meeting I attended this month, a Council member gave a presentation on the benefits of joining the new professional body. While there was plenty of talk of leadership and networking and webinars and mentoring, there was little of how this would relate directly to me.

In just a few months, we will have a new professional body for pharmacy and the big multiples have indicated that they will fund their employees' subscriptions for the first year at least. So there is still time for Lambeth to show it can roll up its sleeves and deliver on the issues that matter to individuals in their day-to-day practice.

The prospect of an organisation that is struggling to engage with the majority of its members a year from now is not one that would benefit a profession on the cusp of major progression. The window of opportunity is small.

**Gary Paragpuri, Editor**

## News



## Features

# The 'Stop Remote Supervision' candidates in election triumph

Contenders take nine of the 11 seats in England and two in Wales in board elections

**Chris Chapman**
chris.chapman@ubm.com

The Stop Remote Supervision (SRS) candidates backed by the Pharmacists' Defence Association (PDA) have swept the RPSGB board elections, claiming all seats contested in a landslide victory.

The candidates took nine of the 11 seats in England and two in Wales for the national boards of the future professional leadership body (PLB). The PDA did not endorse any candidates for the Scottish Board.

Former RPSGB Council member Graham Phillips, current treasurer John Gentle and Locum Voice founder Lindsey Gilpin were among those elected to the English Board.

The SRS candidates in England polled around three times the number of votes as the nearest runner-up, the narrowest margin being victorious Graeme Stafford's 2,870 votes compared with runner-up Nick Barber, who polled 1,291 votes.

English Board member and SRS candidate Graham Phillips welcomed the result as a "very clear mandate, a sense of how the profession wants to be represented".

And the PDA hailed the result as "staggering", with chairman Mark Koziol describing the victory as a "signal to all employers".

"Employee pharmacists have fired a warning shot across the bows of their employers by failing to back senior company candidates," Mr Koziol added.

However, one pharmacy superintendent told C+D that the Society board members should take a broad view of the pharmacy agenda and be all-inclusive, taking major employers with them. "Otherwise they risk employers not paying membership fees, leading to pharmacists not rejoining the PLB in the future," he warned.

Around 21 per cent of pharmacists voted in the elections, with just over 8,000 votes cast nationally. The full results are available online at www.chemistanddruggist.co.uk.

## The victors

ENGLISH PHARMACY BOARD

- Sultan Dajani
- Graham Phillips
- Graeme Stafford
- Martin Astbury
- John Gentle
- Lindsey Gilpin
- David Branford
- Susan Kilby
- Shilpa Gohil
- Tristan Learoyd
- Catherine Armstrong

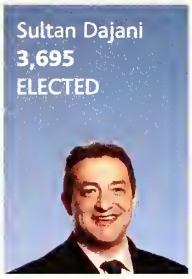
SCOTTISH PHARMACY BOARD

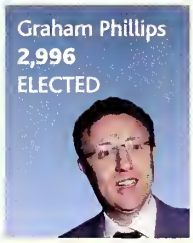
- David Thomson
- Anne Boyter
- John Cromarty
- Alpana Mair
- Alistair Jack

WELSH PHARMACY BOARD

- Mair Davies
- Marc Donovan
- Robert Gartside
- Keith Davies
- Edwyn Parry
- Brian Hawkins
- Diane Heath

**How some of the candidates for the English Pharmacy Board fared in the 'any sector' vote:**







# Society 'broadens search' in CEO quest

The RPSGB has launched a "broad search" for its new CEO and has promised candidates the possibility of a significant pay increase, C+D understands.

In an email shown to C+D by a possible candidate, headhunters Saxton Bampfylde, which have been hired by the Society, offered to discuss its "current, rather broader search" for a chief executive.

It said the closing date for applications was February 2, adding: "Please note that we are very willing to hear cases for a significant increase in the original salary figure, depending of course on experience."

The Society played down the email, saying it was "not in a race" to make the appointment. "We are committed to finding the right candidate and recognise the need to offer a 'market attractive' package to achieve this," a spokesperson said.

But Umesh Modi, a partner at accountancy firm Silver Levene, said the offer to significantly increase salary was "worrisome" at a time when most people were not getting pay increases.

An information document for candidates revealed the CEO would be offered a six figure salary with benefits including private medical care, 30 days holiday and a £500 monthly car allowance. Mr Modi said this seemed "normal" given the role in question, but one London contractor said the deal sounded "too good to be true". **ZS**

# Eight responses to consultation

Just eight pharmacy stakeholders responded to a government consultation on the constitution of the future pharmacy regulator.

The proposals for the General Pharmaceutical Council (GPhC) included establishing maximum terms for GPhC council members and determining grounds where officials may be dismissed.

All the Department of Health (DH) measures were given majority approval. And the single figure response to the consultation was in line with expectations, according to the DH. A similar consultation on the General Dental Council had received six responses, it said.

Respondents to the GPhC constitution proposals included the RPSGB, but the NPA, PSNC and CCA did not respond.

PSNC said it had played a "key role" in developing the draft standards, and was "satisfied" they were "robust and forward-looking".

NPA head of external relations Stephen Fishwick said it had "responded to numerous GPhC-related consultations" and would "remain in dialogue with government". And CCA chief executive Rob Daracott said the constitution consultation was "just a formality, as the discussion had been ages ago". **MG**

## Consultation replies

**How the rate of response to the GPhC constitution compares:**

- **Pharmacy white paper >350**
- **Pharmacy Order 195**
- **Fees for regulation of pharmacy premises 14**
- **GPhC constitution 8**

# Sibutramine suspension 'unscientific', says expert

National Obesity Forum chair says loss of drug will have 'huge impact'

**Chris Chapman**
chris.chapman@ubm.com

A leading obesity expert has slammed the decision to suspend weight loss drug sibutramine as "preposterous, totally naïve and unscientific".

The comments came as pharmacists were advised to stop dispensing sibutramine immediately and return stock to wholesalers following the drug's suspension by the European Medicines Agency (EMA) last week (see box right).

However, the decision was dubbed "bizarre" by National Obesity Forum (NOF) chair David Haslam, as the study involved patients in whom sibutramine was contraindicated.

"It is therefore a little preposterous, and totally naïve and unscientific to unconditionally suspend the drug on these grounds," Dr Haslam told C+D.

The removal of sibutramine as a weight loss option would have a "huge impact", warned Dr Haslam, as orlistat was the only medical alternative.

However, pharmacist John Goes, who was part of an NOF award-winning obesity service in Coventry, said he did not believe sibutramine's suspension would hinder pharmacy-led weight management. Mr Goes said: "Patients have to be educated on proper eating – that would benefit them more in the long run."

The NOF is an independent professional organisation. It lists Abbott Laboratories, which makes sibutramine (Reductil), as one of a range of partners.

## The EMA decision

- Decision triggered by results from SCOUT trial, which followed nearly 10,000 patients for up to six years.
- Trial found a 16 per cent increased risk of cardiovascular (CV) events with sibutramine compared with placebo.
- Most patients in study were contraindicated for sibutramine as they had known CV disease.
- EMA declared data relevant as obese/overweight patients have a higher risk of CV events.
- EMA ruled benefit of sibutramine as a weight-loss aid was modest and did not outweigh cardiovascular risk.

# Adherence must improve, MPs tell DH

Nationally agreed community pharmacy services designed to improve medicines adherence should be commissioned by all PCTs, a Labour MP has told the government.

All-party pharmacy group (APPG) chair Howard Stoate has written to health minister Mike O'Brien, calling for a more central role for community pharmacists in tackling poor adherence. The letter follows last week's APPG meeting (C+D, January 23, p6).

Pharmacists' "major" potential to improve adherence was being "hindered by inconsistency among PCTs", Dr Stoate said. He added that they must be given the opportunity to do so.

Georgina Craig, of the NHS Alliance Pharmacy Commissioning Network, agreed PCT commissioning of pharmacy adherence services needed improvement. "We need a clearer understanding of how the evidence around compliance interventions translates into commissioning must dos," she said.

"Realistic levels of funding" and access to care records were also needed, Dr Stoate added. **JR**

# Homeopathy critics plan Boots protest

Homeopathy critics were expected to stage protests outside Boots stores across the UK this weekend.

The action against "unethical" pharmacy sales of homeopathic products was backed by one of the country's leading complementary therapy experts.

But Boots defended its sale of the remedies as part of a commitment to provide a "wide range" of health products to suit "individual needs".

At exactly 10.23am on January 30, protesters will gather outside town centre Boots branches in 12 cities including London, Bristol and Manchester and consume full bottles of homeopathic remedies.

This "overdose" action was intended to demonstrate the "ineffectiveness" of homeopathy, protest organiser the Merseyside Skeptics Society said.

"We believe that it is unethical for a registered pharmacist to sell these pills," said spokesperson Martin Robbins.

Boots said its pharmacists were trained healthcare professionals, and were on hand to offer advice on the safe use of complementary medicines.

Pharmacy homeopathy is under fire

The 10:23 campaign was supported by Edzard Ernst, professor of complementary medicine at Exeter University. He said the action was justified as an expression of growing public concern "about the NHS wasting money on homeopathic placebos". **MH**

## C+D email address change

The email addresses for the C+D team have changed from January 25. The format for an individual team member will be firstname.surname@ubm.com. For general editorial enquiries, email **haveyoursay@chemistanddruggist.co.uk**.

## UK medicines reach Haiti

Planes carrying medical supplies donated by UK pharmaceutical companies are now reaching Haiti. The first of "many" planned flights touched down in the country, stricken by a seven-magnitude earthquake, late last week. UK pharma has pledged £5.6m to date.

## NHS in England 'better'

The NHS in England is more efficient and provides better value for money than elsewhere in the UK, says The Nuffield Trust, which measured the four home nations against performance indicators such as staffing and waiting times.

## Society CPD report

The RPSGB is due to publish a report on the first six months of its CPD 'call and review' scheme. A spokesperson told C+D the report was due for the end of January.

## Premises tests

Northern Irish pharmacies must meet stricter premises standards, including accessibility for people with disabilities and adequate toilet facilities to convey a more professional image under the PSNI standards.
**www.chemistanddruggist.co.uk**

## Fake Alli warning

The MHRA has warned patients against buying medicines from unregulated websites after counterfeit Alli, containing the unlicensed ingredient sibutramine, was found in the USA.
**www.chemistanddruggist.co.uk**

## Template wins praise

New standards for providing sexual health services have been hailed as an "essential tool" by commissioners. The MedFASH and BASHH standards detail what services should be on offer and how they should be delivered.
**www.chemistanddruggist.co.uk**

# Dispensary talk

## At what age do you plan to retire?

"My mortgage is paid in two years' time; that eases the burden. I won't necessarily retire, perhaps just ease up a bit. But I'd like to think I'll continue as long as I'm competent and enjoying things. And I do enjoy it, the contact with the public – I think it keeps you in touch with things."
**Lorraine Moore, Rowlands Pharmacy, Sunderland**

"Five years ago! In fact, seven years ago! I'm way over retirement age, but I enjoy my job too much to give it up just yet. I'm in the fortunate position of being able to retire whenever I want but I've no plans in the short term. Whenever I get fed up."
**Charles Michie, Charles Michie Pharmacy, Aberdeen**

## Web verdict

**40-50** 9%

**50-65** 56%

**65+** 14%

**I don't plan to retire** 22%

**Armchair view:** You seem pretty set on this one: two thirds of C+D readers have no intention of working past the state pension age of 65. However, a determined 22 per cent (gluttons for punishment?) don't plan to retire at all.
**Next week's question:** Should pharmacists sell homeopathic products? Vote at **www.chemistanddruggist.co.uk**

# Government denies supermarket threat

Health minister says small firms are not being forced out of business

**Zoe Smeaton/Andrew Alexander**
zoe.smeaton@ubm.com


**Patients campaigned to save Notts pharmacy Mistry's after a Tesco 100-hour bid**

There is no evidence that supermarkets are driving small pharmacies out of business, the government has insisted.

But contractors have challenged the view, saying supermarkets have had a negative impact on their pharmacies, particularly taking away custom in the OTC market.

Health minister Gillian Merron made the comments after MPs urged her to protect small firms from supermarket competition. Graham Allen MP had asked a parliamentary question following a patient campaign backing Mistry's Pharmacy in Nottingham when Tesco applied to open a 100-hour pharmacy next door (C+D, January 23, p6).

Mr Allen said: "Will the department pull together some of the big supermarkets and the representatives of the pharmacy associations to discuss a sensible way forward so that such battles do not take place?"

Plaid Cymru MP Hywel Williams added that pharmacies in rural areas faced a particular threat from "the predatory practices of supermarkets".

Ms Merron told MPs they were "right to campaign for a vibrant and diverse range of pharmacies", but added: "There is no evidence that supermarkets are driving the smaller operator out of business."

But the threat of supermarkets' buying power was "a real one" for all businesses, according to Lynne Henshaw, Numark's trade marketing director. One contractor with a Tesco store nearby said he had been forced to reduce the size of his retail business since the supermarket had opened. And Kenny Black, managing director at Rowlands, has previously commented that "medicines are being hammered by supermarkets".

Dayaram Mistry, the contractor at Mistry's Pharmacy in Mr Allen's constituency, told C+D that if Tesco were to open the 100-hour pharmacy next door to him it would have a "drastic effect" on his business.

# PSNC sets out targets for next 12 months

PSNC has laid out plans for 2010, highlighting completion of the cost of service inquiry, simplification of the drug tariff and a full review of the electronic prescription service (EPS) as targets.

Chief executive Sue Sharpe said the year would be a "significant one". She promised that the committee would work to restore accuracy in prescription pricing and reiterated a pledge (C+D, January 16, p8) to ensure PCTs were deterred from manipulating script volumes when the global sum is devolved from April.

The committee played down the importance of the general election for pharmacy, with head of NHS services Alastair Buxton saying party policies toward pharmacy were "pleasingly uniform".

Speaking after its first meeting of 2010, the committee also announced it would review the benefits of EPS to "determine its fitness for purpose". Cegedim Rx said this move was "fair" but warned there would need to be enough pharmacists using EPS to evaluate it. And the supplier pointed to an ongoing EPS evaluation being led by Professor Nick Barber at the School of Pharmacy, University of London.

Ms Sharpe also stressed the need to ensure parallel trading did not affect patients, saying a solution would need to "hinge on pharmacists' basic ethical and legal responsibilities". **ZS/CC**

Sue Sharpe on the cost of service inquiry
**Read her comment on p13**

## Wales DES launch countdown

The first directed enhanced services for community pharmacy are expected to go live in Wales from April, C+D understands.

Establishing smoking cessation, sexual health, supervision of medication plus syringe and needle exchange services were priorities identified last year by an expert group set up to review Welsh pharmacy services.

Chair Chris Martin told C+D work was progressing on the recommended improvements. "We hope to have the launch of the four directed enhanced services in April," he said.

Work had started on a national medicines management strategy, and targets for local health boards to encourage repeat dispensing and 28-day prescribing had been added to the NHS operating framework, Mr Martin added. **ZS**

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# Swine flu: it's not over yet

Swine flu may have slipped off the public radar, but pharmacists must stay alert to the threat and consider vaccination, says **Chris Chapman**

Last week, England's chief medical officer described levels of pandemic flu as "very low". The second wave of swine flu, which was predicted to emerge in October, was "virtually" over, Sir Liam Donaldson added.

The feared pandemic, with pharmacies under siege from desperate patients and supermarkets emptied through panic buying, never materialised.

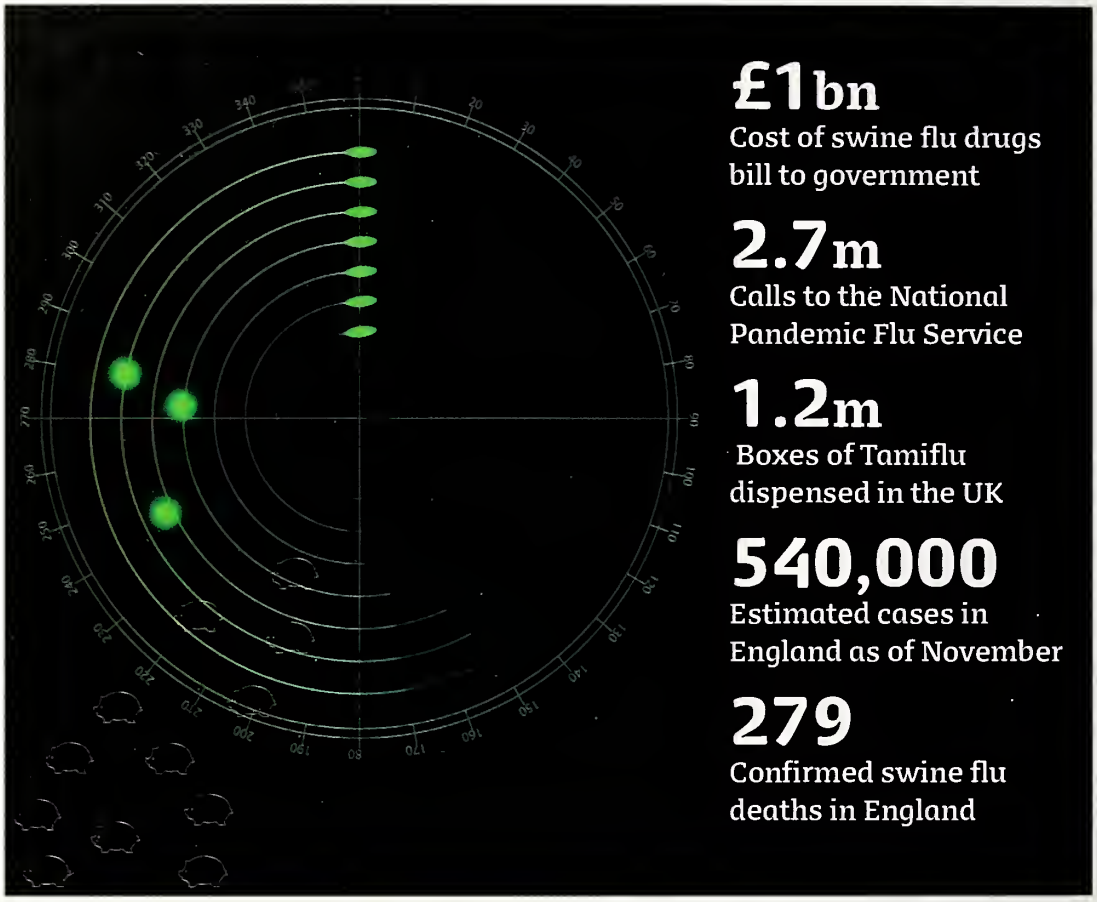
So what happened to swine flu?

The answer lies with the H1N1 virus itself. Swine flu has been mild compared with the three pandemic influenza outbreaks of the 20th century. A Department of Health (DH) study published in the British Medical Journal (BMJ) revealed that although more than half a million people in England had caught the H1N1 virus by November, only 26 patients per 100,000 died. According to health minister Gillian Merron, 80 per cent of patients who have died to date had an underlying condition or pre-existing disease.

Currently, the Health Protection Agency (HPA) estimates there are less than 5,000 cases of swine flu in the UK, down dramatically on the more than 100,000 patients contacting the National Pandemic Flu Service (NPFS) daily in July. GP consultation rates for flu-like illness are currently only two-thirds of the expected seasonal level. On January 19, the last day for which data is available, 2,725 patients called the NPFS, with more than 1,000 antivirals collected.

The statistics are supported by the experience of community pharmacists. "Things have quietened down," says Amish Patel, whose Hodgson Pharmacy in Dartford is an antiviral collection point. "We're getting one patient a day now, compared with six to 10 before."

Yet the decreased activity doesn't mean the pandemic is over, warns Dr Keiji Fukada, special adviser on pandemic influenza at the World Health Organization. "Our current assessment is that it remains too early to say," Mr Fukada says. "It is unclear whether we will see in the northern hemisphere over the next few months, during the winter and spring period, another significant wave of activity."




**The swine flu pandemic has cost the UK billions in drugs and time off work, but it's unclear if we're over the worst**

> "It is unclear whether we will see in the northern hemisphere over the next few months, during the winter and spring period, another significant wave of activity" THE WHO

Though mild, swine flu has still caused almost 300 deaths in England. As C+D went to press 211 patients were hospitalised with the virus, 62 in a critical condition. Prevention of another wave is therefore a priority, and the main defence is vaccination.

Following its release in October, the swine flu vaccine has been rolled out across the country. Priority vaccinations are still being given to frontline health staff, including pharmacists, and at-risk patient groups such as pregnant women and children over six months and under five years of age.

However, despite advice to accept the jab from health chiefs, vaccine uptake has not been high. Of the almost 13 million doses of vaccine sent to the NHS across England, only 3.7 million have been used to date. The total number of frontline health and social care workers to receive the jab, including pharmacists, is 387,000.

"Uptake hasn't been great," confirms Mr Patel. "My LPC organised six pharmacies to do the vaccine for others. I had six pharmacies to vaccinate, and they all refused the vaccine."

The refusal is unacceptable to Sir Liam Donaldson. He says it is a question of when, not if, swine flu will return, and that low vaccine uptake will cost lives unnecessarily.

"When the virus returns in the 2010 flu season, those who develop complications or die will be doing so from a vaccine-preventable disease."

For pharmacists, the message is clear. Swine flu is still with us. And while it is mild compared with other conditions, vulnerable patients are still at risk. Sir Liam urges anyone who has not taken the vaccine to ensure they get the jab. If they do, he says, the risk to many patients next autumn will largely vanish.

**How is the swine flu pandemic affecting your pharmacy now?**

chris.chapman@ubm.com

Springboard

# Springboard Pre-registration Training Programme 2010-11

**Springboard** is an exciting pre-registration training programme, offered in partnership by **C+D** and **Medway School of Pharmacy**.
**Springboard** covers all aspects of the community pharmacy experience and assists the trainee in making a smooth transition from student to professional.

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For more information on the **Springboard** course, complete the slip below and return to:
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Alternatively, call Kinna on 0207 921 8413 or email kinna.mcconochie@ubm.com

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# What will your medicines adherence service look like?

As MPs conclude that community pharmacy should help patients improve their adherence to medicines, **Zoe Smeaton** asks what the solution to the £100 million problem might look like

As the NHS braces itself for tighter finances next year, now is the time to look for money-saving schemes, experts say. And what better way than to cut the £100 million spent on medicines used incorrectly?

This was the topic up for discussion at a meeting of the all-party pharmacy group (APPG) last week, with community pharmacy emerging high on the list of potential problem-solvers.

Frequently hailed as the "experts in medicines", it seems obvious that pharmacists should be first in line to explain to patients how and why they should take their medication. But Rob Horne, professor of behavioural medicine at the School of Pharmacy, University of London, says the task is not as simple as it sounds.

Professor Horne explained to the APPG that patients could incorrectly take medicines either intentionally or by mistake, and that they needed to be treated individually to try to correct the problem.

Tactics to make it easier for patients to admit to non-adherence might be required, he said. And it was important to identify what a patient's beliefs about a medicine were and then try to present plausible information to persuade them that taking the medicine was worthwhile. A "story" for each individual and each medicine was needed, he stressed.

While pharmacy alone might not be able to achieve this, it is difficult to rely on prescribers to do it, as professor Horne said patients could be reluctant to admit non-adherence to them, believing it could imply a lack of faith in their prescription. The Department of Health (DH) seems to agree, with the pharmacy white paper pledging to strengthen the commissioning of adherence support.

Unfortunately, work on developing a broad role for pharmacy in this area appears to have stalled. The DH commissioned research to see why patients aren't taking their medicines with a view to discussing pharmacy's role but, although expected last August, the report has failed to materialise.

All is not lost though, as PSNC says for now the focus is on finalising a role for pharmacy that would enable the sector to give more support to patients starting on a new medicine for a long-term condition. This could have an impact on adherence, according to professor Nick Barber of the School of Pharmacy, University of London. He says it is helpful to intervene early, when patients are first relating to a new medicine.

The contract negotiator remains coy about the details of the planned service, with Alastair Buxton, PSNC head of NHS services, saying "amicable discussions" are continuing with the DH.

Speculation is rife on the subject. The APPG meeting heard about the possibility of a telephone service, with pharmacists calling patients to offer advice on their new medicines. This approach certainly has some support, as a study in which pharmacists called patients two weeks after they were prescribed a new medicine showed the calls significantly reduced non-adherence after a month.

MURs could also be an option, and in fact can already have benefits in this area. Ash Soni, a community pharmacist in London, told the APPG about the first MUR he had ever conducted, in which he was able to correct a patient on three medicines who had been taking just one a day, rather than all three every day. And a project focusing on asthma patients in Hampshire and the Isle of Wight has shown that delivering MURs can have a real impact on adherence and related health outcomes.

But are MURs really enough?

Mike Holden, chief officer at Hampshire & Isle of Wight LPC, says not, as they don't allow messages to be reinforced over time. "MURs are not the full solution. Most people only take in about one third of what we say and one intervention is not enough," he stresses. Instead he suggests an initial intervention and then follow ups to reinforce the messages, possibly delivered by technicians, or even text messaging.

Mr Soni agrees: "Ideally we don't want this to be a one-off." Instead he suggests pharmacists could talk to patients after the first and second months as well, to address any concerns that have developed. He adds that he would prefer not to have to sit down with the patient in the consultation room to deliver the service either, instead talking to patients at the dispensary.

It is clear that the sector has high hopes for PSNC's current negotiations but, whatever the solution delivered, it will then be down to pharmacists to make it work. As Mr Buxton reflects: "By the end of this decade, I hope we can reflect positively. Maybe we won't have fully solved this, but I hope we'll have made a difference."

## Medicines adherence: the stats

**£100m**
Wasted annually on medicines, according to the Commons public accounts committee

**57%**
Reduction in emergency admissions for asthma seen in targeted MUR project

**11%**
Of households have at least one unused medicine on their shelves, according to a DH commissioned report

**50%**
Of patients with long-term conditions don't take their medicines as prescribed, says the DH

# Panadol Advance scoops award

Panadol Advance has been voted Pain Relief Product of the Year in the Product of the Year Awards 2010.

The awards are designed to recognise product innovation and are based on a TNS consumer survey of over 10,000 people.

Panadol Advance tablets will be given a further boost by a national TV ad campaign running until March 7.

The brand's 'visible man' advertisement, which combines a real man and woman with computer graphics, has been updated to highlight the Pain Relief Product of the Year win.

It also demonstrates how the Optizorb disintegration system disperses in the stomach, allowing the paracetamol to reach the bloodstream quickly.


**GlaxoSmithKline Consumer Healthcare**
**Tel: 0845 762 6637**
**www.mypharmassist.co.uk**

## Market focus

- The £355 million total adult pain relief market has grown by 1 per cent in the last year (Nielsen MAT data October 31, 2009)
- Panadol Advance has helped the overall Panadol brand grow by 12 per cent in the last year – the highest growth in the adult pain relief category (Nielsen MAT data November 28, 2009)

## In brief

### Apotex distributor

LPC (Pharmaceuticals) has been appointed as the distributor for existing Apotex products and future range introductions into the UK wholesale and retail pharmacy market.

**LPC (Pharmaceuticals)**
**Tel: 01582 560393**

### Lederfen discontinued

Goldshield Pharmaceuticals will discontinue Lederfen capsules 300mg from March due to insufficient demand for the product.

**Goldshield Pharmaceuticals**
**Tel: 02085 889273**


# Pasante to relaunch Sebamed

The German Sebamed body and skincare brand will be distributed in the UK by Pasante Healthcare from February 1.

The company is relaunching five Sebamed ranges: Classic Cleansing, Skin Care, Clear Face, Hair Care and Baby.

The soap-free products are suitable for sufferers of eczema, seborrhoea, acne, contact irritation and allergies, hyperhidrosis, bacterial skin infections and burns.

All the products have a pH value of 5.5 to help protect and maintain the natural acid mantle of the skin.

**Pasante Healthcare**
**Tel: 01903 753844**

# Bio-Quinone Q10 reaches for new heights

Pharma Nord has teamed up with world record breaking endurance athlete Noel Hanna, who has joined Dr Chris Steele as a spokesperson for Bio-Quinone Q10.

Last year, Noel (pictured right with his wife) climbed Everest and he recently set a new Guinness World Record in Antarctica. He says: "My wife and I both took Q10 when we scaled Everest. We did not suffer from tiredness or muscle pain and enjoyed a fantastic summit with abundant energy."

Noel will feature in a new consumer advertising campaign for Bio-Quinone Q10, appearing in leading health, men's fitness and lifestyle magazines from February.

The advertising will run in conjunction with an existing campaign featuring Dr Steele.

New point of sale material to support the brand will include double-sided posters in a variety of sizes.

**Pharma Nord UK**
**Tel: 0800 591 756**

## Check what's on TV

**www.chemistanddruggist.co.uk/prodnews**

Check what's on TV this week
www.chemistanddruggist.co.uk/prodnews

## Nurofen gets a new look

Reckitt Benckiser will phase in new packaging for its Nurofen brand in March.

The company says the new look has been created to enhance the brand's shelf standout and consumer understanding of the benefits of the different formats. The new packaging is also designed to reinforce the message that Nurofen 'targets pain right at its source'.

From this month, the brand is being supported by an £11 million multimedia campaign, which includes TV, print, outdoor and online advertising.

The campaign features a simple, magical brand world where consumers see a new animated character, Nuro, going straight to the source of pain to provide effective relief.

Nuro also appears in an eye-catching point of sale kit developed for pharmacies. PoS material includes shelf barkers, wobblers, window posters and strut cards.

**Reckitt Benckiser**
**Tel: 01482 326151**

## Nutrigen sprinkles vits for tots

Nutrigen is launching two nutritional supplements designed to fortify infants' homemade food.

Vitamixin Sprinkles and Ferromixin Sprinkles one-a-day sachets are suitable for babies and young children from six months to two years and can be added to semi-solid homemade food.

Vitamixin Sprinkles contains the Dietary Reference Intake (DRI) of iron together with the DRI of 10 vitamins and four minerals that can help sustain children's energy levels, growth, blood health and immunity.

Ferromixin Sprinkles contain the DRI of iron plus a mix of vitamin A and folic acid to help children receive the nutrients needed to promote healthy blood and developmental growth.


Formulated to be easily hidden in food and undetectable to fussy eaters, both products are odourless and taste-free.

**Price: Vitamixin £6.99/30, Ferromixin £4.99/30**
**Nutrigen**
**Tel: 0844 7042738**

## Sure takes natural approach to deodorants

Unilever has introduced a new line of anti-perspirant deodorants containing natural extracts and minerals into its Sure range.

Sure Natural Minerals combines a naturally occurring mineral complex with anti-perspirant technology, which is claimed to offer 48 hours of protection.

The range has been developed to meet the growing consumer demand for products with natural ingredients without compromising on efficacy, says Unilever.

Available in a roll on and two aerosol sizes, the range comes in two variants: Pure – Orange Blossom & Cranberry, and Fresh – Olive Leaf & Pink Pepper.

The launch is currently being supported by a £6 million media campaign including TV and print advertising, as well as digital and in-store activity.

**Price: £1.69 roll on/50ml, £2.29 aerosol/150ml, £2.99 aerosol/250ml**
**Pip codes: see C+D Monthly Pricelist or www.cddata.co.uk**
**Unilever UK**
**Tel: 01372 945000**



## Corsodyl is back on the TV

Corsodyl will be in the public eye in the coming months, backed by a national TV and press campaign worth £1.95 million.

On air from February 1 for four weeks, the TV campaign will feature the brand's 'gorgeous/missing tooth' advertisement, which shows an attractive woman with an unsightly gap in her teeth.


The advertising focuses on Corsodyl Mint Mouthwash and also highlights Corsodyl Daily Gum & Tooth Paste, which was launched last year.

Both these products will also be supported by an eight-week press campaign from early February. Simple yet compelling messages will be used to inform and educate consumers about gum health in the campaign.

**GlaxoSmithKline Consumer Healthcare**
**Tel: 0845 762 6637**
**www.mypharmassist.co.uk**

## Vaseline rich cream joins range

Unilever has extended its Vaseline Intensive Rescue range for dry and very dry skin to include a rich cream for instant relief against dryness.

Vaseline Intensive Rescue Moisture Locking Cream is formulated to help dry skin repair itself after skin flare-ups, which can happen during dry, cold and windy weather.

The product contains glycerine to increase the moisture level of the skin and petrolatum to act as an occlusive barrier.

It is formulated to be fast absorbing and provide a protective layer without leaving a sticky residue.

**Price: £3.99/225ml**
**Enterprise**
**Tel: 01782 795000**

Xrayser

# Generic substitution, a double-edged sword

> BRANDED GENERICS... BELOVED OF PCTs TO REDUCE THE GLOBAL SUM BY THE BACK DOOR

I thought about the generic substitution proposals today when, yet again, I broke one of my principles and went shopping at Tesco. I have long been an exponent of the Tescopoly theory of the high street, borne out by my pharmacy standing on a parade that has lost its butcher, greengrocer and post office. Soon such terms will seem as old-fashioned as costermonger or, indeed, apothecary!

However, you can only play King Canute for so long, so in I went. Half way round I was looking for Tesco white vinegar – 35p – when I saw next to it Sarsons at 88p, and I thought to myself: "Who would pay extra for branded vinegar?" After all, acetic acid is acetic acid, or $CH_3COOH$ perhaps I should say. How can you have a 'premium' version? I can hear the voiceover now: "This is not just acetic acid. This is hand-carbonylated, oxidatively-fermented acetic acid..."

And so the generic substitution proposals. "About time!" we all say, thinking of the out-of-hours scripts for Augmentin or Frumil that come in late on a Friday night. I can't wait to be able to substitute those legally, instead of the ethical dilemma of doing the "best thing for the patient" and dispensing the usual generic on the basis that it's not appropriate to delay treatment. And we all have patients who swear that only Losec will do, or only Plendil controls their blood pressure. Of course, it's not just brands. We also have the patients who swear they can't have Teva omeprazole, or they only want Dr Reddys paroxetine. Yet Ventolin inhalers never clog like the generics do. And ever taken Fybogel? It's not great, but I don't know that I'd be as compliant with the orange-flavoured wallpaper paste that masquerades as generic ispaghula husk, so maybe sometimes patients have a point.

But why do we need yet another list? The BNF tells us the few drugs that aren't appropriate to switch. You might say the DH wouldn't want us to be able to substitute just anything because then they wouldn't be able to claw back even more danegeld by the prescribing of 'branded generics', those wonderful oxymorons beloved of PCTs to reduce the global sum by the back door. And far be it from me to suggest that pharma companies might wish to lobby for their brands to be removed from 'the list for substitution', but how better for a politician to understand the complex science of bioequivalence than to have a directorship on the board of that company...

So, do I think it's a good thing to save £164 million? Yes. Do I think it's good for patients? Not sure now. Do I think pharmacy will see any of that £164 million? Let's put it this way – I'm not going to be splashing out on Sarsons any time soon.

Sue Sharpe

# Do your bit to help the cost of service inquiry

Community pharmacy contractors hold a unique position in the NHS primary care network. They are (as the Conservatives noted in their recent public health Green Paper) "a vital resource for healthcare and condition management" and are "many people's most frequent link to a knowledgeable health professional". They are also retailers and business owners, delivering a high quality service while keeping an eye on the bottom line.

This model harnesses pharmacists' natural drive to provide the highest standards of patient care, and creates clear incentives for contractors to offer greater access and a broader range of services. Indeed, at PSNC's recent question time event, all three major parties endorsed the benefits of pharmacy contractors' twin roles.

Accurate reimbursement of contractors for the costs of the medicines and services they supply is central to this system. Prompt and steady reimbursement is needed to fund contractors' investment in new services; investment the parties agree is a priority in improving public health and wellbeing outcomes.

Since 2005's contractual framework, pharmacy has developed dramatically, with pharmacists taking on a far broader role in providing key NHS services. This laudable progress in policy must now be matched by development in funding arrangements. Pharmacy funding systems should encourage investment in new services and empower pharmacy to fulfil its clinical potential. They should be carefully tailored to incentivise the innovation of the future.

This year's cost of service inquiry provides a chance to ensure funding arrangements reflect and further stimulate development in the role of community pharmacy. We must ensure that the inquiry fully reflects all pharmacy businesses' costs, from the smallest independents to the largest multiples. The cost drivers that will influence pharmacies in the future must also be adequately reflected. Financial constraints inevitably mean that a new government will look closely at the results of the inquiry – this makes it all the more important that pharmacy makes a compelling case for further investment.

PricewaterhouseCoopers (PwC), which is conducting the inquiry, is writing to contractors who will make up its sample evidence group. It is crucial that all pharmacists who are contacted, especially independents, report their costs as thoroughly as possible. Filling in the COSI forms may seem tedious. But only through rigorous documenting of all associated costs will we achieve a fair and accurate settlement.

**Sue Sharpe is chief executive of PSNC**

> PHARMACY'S BROADER ROLE IN PROVIDING NHS SERVICES... MUST BE MATCHED BY DEVELOPMENTS IN FUNDING



30.01.10

# Features

Update

Your weekly CPD revision guide

Module 1511

# Treating insomnia

## Best practice guidelines on the use of hypnotics

Need specific CPD resources? Check our massive clinical index

www.chemistanddruggist.co.uk/clinicalindex

## 60-second summary

This article, which can be used for CPD purposes, describes which hypnotics are best for insomnia and for how long they should be taken.

### What are the latest recommendations?

Nice suggests short-term use of a short-acting hypnotic, such as a Z-drug or temazepam, only if insomnia affects daytime functioning. Long-acting benzodiazepines and other sedatives are not recommended.

### How long should hypnotics be used?

Ideally for only a week (up to three weeks at the most) and not every night. Patients should be encouraged to take them only if necessary. All the recommended hypnotics can cause dependence.

**This article (Module 1511) can help in the following CPD competencies: G1a, G1c, G1d, G1s, C1a, C1b, C3b.**
**See http://tinyurl.com/68ox7b**



**Asha Fowells MRPharmS**

### The case study

It's a steady morning in the pharmacy, and you have just given out a 'shopping list' prescription to a regular patient who has coeliac disease, when a middle-aged woman approaches you. You recognise her as a regular customer, recalling that she doesn't get her prescriptions dispensed at your pharmacy but has asked about health-related matters on several occasions. This time, however, she shows you a prescription for 'diazepam 5mg tablets, one at night, supply seven'. She explains that the prescription is for her mother-in-law, and says: "She's terribly worried about taking these – aren't they Valium? She just needs a bit of help sleeping as her sister recently passed away. She doesn't want to get hooked on anything."

### Insomnia – how is it defined?

Insomnia is a condition in which an individual finds it difficult to go to sleep or stay asleep, suffers from early wakening, or feels that their quality of sleep is inadequate despite having enough time and opportunity. The result is impaired daytime functioning, such as tiredness, poor concentration and clumsiness.

There are two types of insomnia: primary insomnia, which occurs in the absence of any other medical condition and is usually due to learned sleep difficulties; and secondary insomnia, which occurs as a result or symptom of another condition, for example psychiatric illness or substance misuse (see panel top right). Insomnia may be further classified as short-term (lasting between one and four weeks) and long-term (lasting four weeks or longer, and often persisting for several years).

It appears that the patient for whom the diazepam has been prescribed is suffering from primary insomnia (she is a generally healthy 70-year-old, taking a statin for her cholesterol but no other medication) of short-term duration (the problem only started two weeks ago when her sister passed away). Although the recent bereavement is generally viewed as a relief (the sister having been in a hospice with terminal cancer for several weeks), the patient is struggling to cope with her normal daytime activities through lack of sleep, so consulted her GP.

### Hypnotics – what Nice says

Hypnotics (drugs that induce sleep) are considered appropriate for short-term insomnia if the condition is having an impact on normal daytime function, and once any underlying causes or co-morbidities have been eliminated (or identified and addressed). According to the National Institute for Health and Clinical Excellence (Nice), the hypnotics considered suitable for this indication are the short-acting benzodiazepines (temazepam, lormetazepam and loprazolam) and the Z-drugs (zopiclone, zolpidem and zaleplon). Drugs deemed not suitable by Nice include the longer-acting benzodiazepines nitrazepam and flurazepam, sedative drugs that are not hypnotics (such as barbiturates, antidepressants, antihistamines, chloral hydrate and chlormethiazole), melatonin and valerian. Two longer-acting benzodiazepines (diazepam and lorazepam) are licensed only for insomnia that is accompanied by daytime anxiety.

Nice places great emphasis on the fact that hypnotics should be prescribed only as a short-term measure for insomnia that is not being resolved by non-pharmacological measures. The guidance highlights the lack of evidence supporting any one short-acting hypnotic (both benzodiazepines and Z-drugs) over any other, and recommends prescribing whichever agent has the lowest cost. Patients who do not respond to the first agent prescribed should not be given an alternative, the guidance explains, and switching should be considered only for individuals who have an adverse reaction that can be directly linked to the hypnotic being used.

According to the British National Formulary (BNF), hypnotics should generally be avoided in the elderly, who are more likely to become unsteady and confused, and to fall and injure themselves as a result of the medication. However, where insomnia is causing severe distress and

### Co-morbidities and substances that can cause insomnia

**Co-morbidities:** psychiatric conditions (including depression, bipolar disorder, anxiety and schizophrenia), angina, heart failure, thyroid dysfunction, asthma, COPD, Alzheimer's disease, Parkinson's disease, arthritic conditions, GORD, IBS, incontinence, BPH, pain.
**Substances:** alcohol, caffeine, nicotine, recreational drugs, SSRIs, MAOIs, beta-blockers, calcium channel blockers, lamotrigine, phenytoin, corticosteroids, thyroid hormones, NSAIDs, methylphenidate, sympathomimetics.

affecting daytime functioning – as is the case with this patient – a hypnotic may be prescribed for a short period (preferably one week, but up to three is considered acceptable).

Ideally hypnotics should not be taken every night, with intermittent use preferred. This is because of the risk of tolerance developing (which can occur within as few as three days of continuous use) and a lack of evidence supporting long-term efficacy. A further drawback of long-term use is that withdrawal can be problematic, not only causing withdrawal symptoms but also rebound insomnia.

## Benzodiazepines

The only benzodiazepines recommended by Nice for insomnia are temazepam, lormetazepam and loprazolam. This is because of their short duration of action, which means they are less likely to cause a 'hangover' effect the next day. The usual dosing is:

- loprazolam: 1mg at bedtime, increased to 1.5-2mg, if needed
- lormetazepam: 0.5-1.5mg at bedtime
- temazepam: 10-20mg at bedtime, increased to 30-40mg if needed.

For elderly patients, it is advisable to stick to the lower end of the recommended dose range.

However, even short-acting benzodiazepines are not problem-free. The short duration of action of loprazolam, lormetazepam and temazepam means that these three drugs are more likely than long-acting hypnotics to cause benzodiazepine withdrawal syndrome – sometimes even within a day of starting treatment. The syndrome is characterised by insomnia, anxiety, appetite and weight loss, tremor, sweating, tinnitus and disturbances in perception – any of which may have led to the drug being prescribed in the first instance. Furthermore, these withdrawal symptoms can continue for a number of weeks or even months.

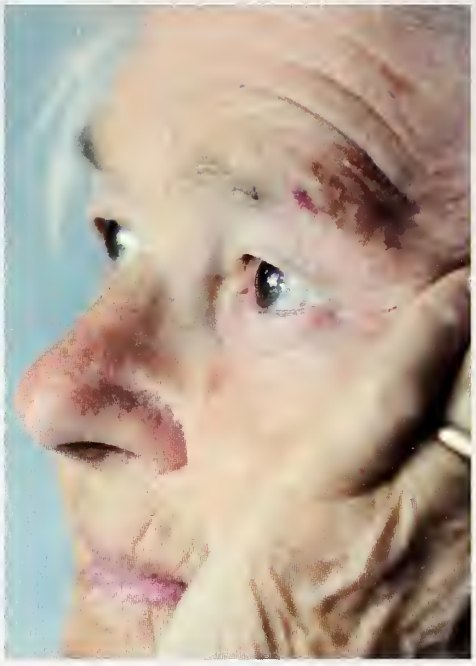
Where diazepam is prescribed for insomnia (and this should occur only if the patient displays symptoms of daytime anxiety as well as disturbed sleep), the recommended dose is 5-15mg at bedtime.

By questioning the woman who has brought the diazepam prescription into your pharmacy, you discover that her mother-in-law is managing well during the day, apart from feeling very tired from lack of sleep. This makes you think that diazepam is not suitable for her insomnia, and you turn your mind to non-benzodiazepine alternatives.

## Z-drugs

Z-drugs are non-benzodiazepine hypnotics, though they work at benzodiazepine receptor sites. The recommended doses are, at bedtime:

- zaleplon: 10mg (elderly or debilitated 5mg)
- zolpidem: 10mg (elderly or debilitated 5mg)
- zopiclone: 7.5mg at night (elderly 3.75mg initially).



absolut/Fotolia

**An elderly woman is prescribed diazepam to help her sleep after her sister's death. This article explains why zopiclone would be a better choice**

Of the three agents in this class, zaleplon is the shortest-acting, though zopiclone and zolpidem are also considered short-acting drugs. However, despite their short duration, dependence can occur and all three are licensed only for short-term use. Other side effects are relatively uncommon, but can include gastrointestinal disturbances such as nausea, diarrhoea and altered taste, and the adverse effects associated with all hypnotics such as confusion, depression and sleep disturbances.

You decide to telephone the patient's GP, and find her receptive to your idea of changing the prescription from a benzodiazepine to a Z-drug. You agree on zopiclone at a dose of 3.75mg at bedtime, based on the patient's age.

The GP generates a new prescription during your telephone conversation and says she will ask her receptionist to fax it through to you immediately before putting the original in the post. She is as good as her word, and within five minutes you have received a faxed prescription for seven tablets.

The prescription is accompanied by a note asking you to advise the patient to try to avoid regarding the medication as a course of treatment and only take a tablet if she is really struggling to get to sleep. If the problem persists, the patient should return to her GP for advice rather than requesting a repeat prescription, the note adds, alongside a plea for you to give some advice on sleep hygiene.

## Associated advice

Insomnia often benefits from changes in routine that improve the quality of sleep (sleep hygiene). These include:

- getting up and going to bed at the same time each day
- avoiding daytime naps
- establishing a bedtime routine, such as having a warm drink or bath to aid relaxation
- ensuring the bedroom is an environment conducive to sleep by not using it for other activities such as work or watching television
- ensuring the bedroom is not too hot or cold, and that the bed is comfortable
- avoiding alcohol in the evening – although it can help the individual get to sleep, it is more likely to cause waking during the night
- avoiding stimulants such as caffeine and nicotine in the evening
- exercising during the day, but not in the hours immediately before bedtime
- avoiding heavy meals shortly before going to bed.

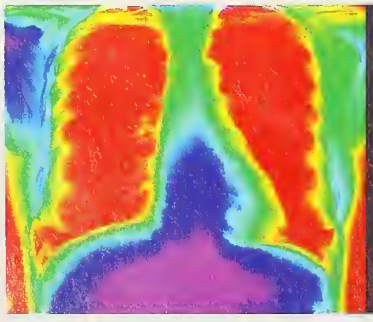
Rather than providing all the above information to the lady who has brought in the prescription, a more sensible option would be to give her a leaflet she can pass on to her mother-in-law (the patient). You decide to print off the Sleeping Well leaflet published by the Royal College of Psychiatrists (see details below), which the customer gratefully accepts along with the newly prescribed zopiclone and the message about avoiding continuous use as requested by the GP.

## Further information

- Nice Technology Appraisal 77, Zaleplon, zolpidem and zopiclone for the short-term management of insomnia, available at http://guidance.nice.org.uk/TA77.
- The NHS Clinical Knowledge Summaries include an overview of insomnia, available at http://www.cks.nhs.uk/insomnia#.
- The Royal College of Psychiatrists publishes patient leaflets on a wide range of psychiatric conditions, including insomnia, available at http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/sleepproblems/sleepingwell.aspx

**Asha Fowells MRPharmS is a practising community pharmacist, and a training development manager at C+D.**

**Update subscribers: download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.**



## Treating insomnia

**Reflect**

What are the Nice recommendations for treating insomnia? Why should hypnotics generally be avoided in the elderly? What are the side effects of the Z-drugs?

**Plan**

This article describes the use of hypnotics in the treatment of insomnia. It has information about the latest Nice recommendations and discusses the use of benzodiazepines and Z-drugs as well as good sleep hygiene.

**Act**

- Find out more about the treatment of insomnia on the NHS Clinical Knowledge Summaries website at http://tinyurl.com/ybqp4pm.
- Read the Royal College of Psychiatrists' leaflet on sleeping well, which could be useful to give patients, at http://tinyurl.com/crzmd6.
- Read section 4.1 Hypnotics and anxiolytics in the BNF including the information on benzodiazepine withdrawal. Think what you would do if you thought a patient had been taking hypnotics for too long – how would you approach both patient and prescriber? Information for patients about stopping benzodiazepines is on the Patient UK website at http://tinyurl.com/yey6wgc.
- Think about the advice you could give to a patient requesting an OTC sleep remedy.

**Evaluate**

Are you now confident in your knowledge of the use of hypnotics in insomnia? Could you advise patients about non-drug methods to help?

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Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

**Practical Approach** Test yourself in this everyday pharmacy scenario

# A CD script from an independent prescriber

David Spencer, pharmacist at the Update Pharmacy, has received a phone call from the local Royal Pharmaceutical Society inspector saying he has had a complaint about the apparently unlawful supply of a controlled drug from the pharmacy, and will be visiting to investigate.

When he arrives he explains: "We had a report that a prescription for 24 co-codamol 8/500 tablets, written by a pharmacist independent prescriber, was dispensed here. We have verified that by obtaining the prescription from the NHS pricing office. The supply may constitute an offence against the Misuse of Drugs Act 1971."

David asks when the prescription was dispensed and the inspector tells him.

"I was actually on holiday at that time," says David, "so it must have been dispensed by the agency locum. But in any case, I can sell co-codamol tablets over the counter, so how can dispensing them be an offence?"

The inspector explains. David asks: "So what are you proposing to do?"

"I'm afraid that I have no discretion. I have to prepare a report for the Society's Investigating Committee. It will decide what action to take. Technically, a Misuse of Drugs Act offence is a police matter, but I'm hoping we won't need to refer it to them."

When the inspector has gone, David considers what the locum might have done to avoid this situation arising.

## Question

**1. What is the difference between a pharmacist independent prescriber (PIP) and a pharmacist supplementary prescriber (PSP), and what can they prescribe?**
**2. Why can a PIP not prescribe co-codamol tablets?**
**3. Is David likely to be subject to any disciplinary action?**
**4. What might the locum have done to avoid the situation?**

## Answer

**1.** A PIP is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing. A PSP works in partnership with a doctor (or dentist) to implement an agreed patient-specific clinical management plan (CMP) with the patient's agreement. PIPs can prescribe any licensed medicine for any condition within their clinical competence, excluding controlled drugs. PSPs can prescribe any drug within a CMP, including controlled drugs.

**2.** Co-codamol 8/500 tablets are classified as CD Schedule 5 and are P medicines up to a quantity of 32 tablets. However, they are still CDs and cannot be prescribed by a PIP, although arrangements are in hand to allow PIPs to prescribe all CDs.

**3.** No. Although David is the pharmacy superintendent he had no responsibility for the locum's action in dispensing this prescription. The locum received a "letter of advice" from the Investigating Committee, which is kept on his disciplinary record for five years.

**4.** PIPs prescribe on an FP10(P) form annotated 'Pharmacist Independent/ Supplementary Prescriber'. It is therefore not possible to distinguish a PIP from a PSP from the form. The locum should have realised that co-codamol is a CD and checked whether the prescriber was a PSP, when co-codamol could be legitimately prescribed under a CMP, or a PIP, when it could not be prescribed or dispensed.

This article can help with these CPD competencies: **G1h,G1j, G2k, G4a, G5c.**
**See http://tinyurl.com/68ox7b**

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practical approach**

# New rules for

A new Nice guideline has increased gluten-free food prescriptions, as standards for the products change, reports **Gavin Atkin**

The year 2009 must have been one of the busiest periods the coeliac disease and specialist coeliac foods supply communities have ever known.

Last year saw manufacturers implementing a tight new international standard for gluten-free foods, while a widely publicised Nice guideline aimed at finding thousands of individuals with undiagnosed coeliac disease has boosted prescriptions for gluten-free foods (see Nice guidance on coeliac screening, below right).

## Defining 'gluten-free'

Let's focus on that food standard. The Codex Alimentarius is an international body that sets standards for a bewildering array of products, ranging from exotic-sounding foodstuffs such as canned foul medames and dried shark fins, to familiar items such as tinned pineapple and infant milk powders – and includes food standards for coeliacs among its responsibilities.

Coeliac UK's Sarah Sleet explains: "Years ago, Codex issued a standard that said any food that contained less than 200mg/kg of gluten could be classified as gluten-free. That standard remained in place for a long time, but caused a huge debate because different countries took different views about what was a tolerable level of gluten."

A key problem has been that those who took part in the debate have not had much scientific evidence to go on. Workable data is difficult to gather, Ms Sleet says, because of the range of products and varying diets and gluten sensitivities of coeliac disease patients.

In practice, countries have tended to base their gluten-free food policies on their own traditions and attitudes to risk rather than on science. For example, the US and the Mediterranean countries imposed upon themselves a much lower level than 200mg/kg, Ms Sleet explains.

"But in the Northern European countries there has been a tradition of eating substitute products that contain traditional Codex wheat starch that has been specially washed to reduce the gluten content."

## Lowering the bar: a new international standard

The paradigm changed after an Italian biopsy study found that for some people gluten levels as low as 50mg/kg could have a detectable effect on their gut. This biopsy study included just 40 subjects and, while it's striking that a decision with such large health and commercial implications should be based on a sample so small, people don't easily volunteer for studies in which they will be biopsied again and again – and so the chances of getting a large-scale study to confirm the finding is remote.

Based on the evidence available, the Codex committee negotiated and finally endorsed a standard to be dubbed 'gluten-free'. This is the new standard 20mg/kg or below, which is based on the principle that even the most sensitive coeliac individual should be able to eat as much of

## Coeliac disease: what you need to know

- **Changes in Nice guidance have meant growing numbers of coeliacs being identified.**
- **The existing 200mg/kg standard for gluten-free food in the UK is rapidly being replaced by the new 20mg/kg standard – ahead of its January 2012 official launch.**
- **Patients who travel abroad may find products to the very low gluten standard of 100mg/kg – this is low enough for most unless they are very sensitive.**
- **Pharmacy gluten-free food repeat prescribing schemes help standardise prescribing practices and save time.**

# gluten-free foods

a food made to the 20mg/kg standard as they liked without problems.

Perhaps confusingly, Codex also came up with a second level, 100mg/kg or below, which is described as 'very low gluten'. This second level is based on the principle that coeliacs not in the most sensitive group could safely consume foodstuffs at this level of gluten based on the premise that they are unlikely to eat enormous quantities of a single food containing gluten.

> "A key problem has been that those who took part in the debate have not had much scientific evidence to go on"

## The UK approach

In fact, suppliers in the UK have largely rejected the double standard and have instead coalesced around the lower level – many of the companies who were making Codex wheat starch were already working to bring their gluten levels down, and so the change hasn't brought problems for the gluten-free food industry. In the UK market, the two biggest brands – Glutafin and Juvela – have both now reduced their products down to 20mg/kg and are labelling their products gluten-free, even though the new standard doesn't officially come into play until January 2012.

Juvela commercial director John Phillips explains there were two reasons for going over to the new gluten-free standard early. "One is that many products in the gluten-free market were already at the new gluten-free standard; the other is that from a patient perspective, they have been buying products marked gluten-free for many years, and that changing the labelling from gluten-free to very low gluten would cause some confusion.

"The fact is that products don't have to be labelled in the new way until January 1, 2012 – but Juvela's products have all been gluten-free to the new standards for some months now, and in some cases for years."

## Pharmacists' role

Companies may have been wise to move to the new standard in order to be able to retain the familiar gluten-free label, but customers for gluten-free foods are nevertheless likely to ask pharmacists questions about the products they buy, and in particular whether they meet the old 200mg/kg standard or the new 20mg/kg standard. Mr Phillips argues pharmacists will need to be able to equip themselves to deal with these as they arise, and warns they'll also need to be aware that gluten-free foods are also subject to changes such as lowering salt content that are also taking place in relation to ordinary foods.

"Reducing salt levels may mean that patients will say, 'Oh, this tastes different to how it used to'." When they do, it won't necessarily be connected with the new standard, but may be due to changes in the general food standards applied by the government, says Mr Phillips.

Pharmacists may also be able to advise coeliac patients thinking of travelling, says Ms Sleet. "The Nordic countries want to keep their products as they are as near as possible, and travellers should be aware that they won't be able to find all the products they are used to everywhere in Europe," she explains. "However, they can be told that wherever they do travel they should still be able to identify whether products conform to the 20mg/kg or 100mg/kg standards, and that most coeliacs will be able to eat moderate quantities of foodstuffs made to the 100mg/kg standard without problems."

## Nice guidance on coeliac screening

**Published in May last year, the latest Nice guideline on coeliac disease sets out to identify the many thousands of individuals in the community with as-yet undiagnosed coeliac disease, often because they do not have the classic gastrointestinal symptoms. The concern is that these patients may be susceptible to the long-term effects of coeliac disease, which include cancers.**

**According to Nice, doctors should offer serological testing for coeliac disease to children and adults with any of the following:**

- **chronic or intermittent diarrhoea**
- **failure to thrive or faltering growth (in children)**
- **persistent or unexplained gastrointestinal symptoms, including nausea and vomiting**
- **prolonged fatigue**
- **recurrent abdominal pain, cramping or distension**
- **sudden or unexpected weight loss**
- **unexplained iron-deficiency anaemia, or other unspecified anaemia**
- **auto-immune thyroid disease, dermatitis herpetiformis, irritable bowel syndrome or type 1 diabetes**
- **first-degree relatives with coeliac disease.**

## Case study: Allerdale pharmacies

Coeliac disease campaigners and gluten-free suppliers are closely following the progress of a new pharmacy-based scheme in which GPs prescribe a year's worth of gluten-free foods and local pharmacists supply products in line with a local protocol.

NHS Cumbria is piloting the service, which will allow patients with coeliac disease living in Allerdale to pick up gluten-free foods from their local community pharmacies without obtaining new prescriptions from their GP.

Why Allerdale? Coeliac UK's Sarah Sleet explains that a local GP who is on the PCT has coeliac disease himself and the local coeliac patients group came up with the idea. 'We know that doctors get frustrated by prescribing gluten-free foods – it doesn't feel like a useful way to use their time – and so do patients, who don't understand why they have to keep going back to the doctor for prescriptions. So there's frustration all round.

"So in Allerdale they came up with a points-based system, and patients draw down against that."

Why did the idea appeal to the PCT? Ms Sleet reports that in addition to greater patient convenience and saving GPs' time, a key selling point is that practices vary greatly from prescriber to prescriber, with some prescribing rather more gluten-free food products than others. "Schemes like this make prescribing more consistent, and also more visible and understandable, and predictable," she says.

"There are national guidelines that Coeliac UK has negotiated with doctors and the British Dietetic Association that set out volumes of prescribing matched to the nutritional needs of people. If you have prescriptions issued on that basis you will therefore be able to reduce inconsistencies and to predict costs.

"With the financial situation that's going to hit the health service in the next couple of years, people will be looking for savings of a few per cent on everything, including foods for patients with coeliac disease. Running everything just a little better will deliver that, and this is an obvious opportunity."

Overall the scheme is doing well. The latest statistics show some 90 per cent of local coeliac sufferers have now transferred into it (up from 60 per cent at the end of November) and the word from the PCT is that patients see it as a commonsense way of delivering a service that was previously time consuming for both patients and doctors.

## Market Insight

The vitamins, minerals and supplements (VMS) market has had an interesting year that has seen its value fall £12m to £398m. This has largely been due to shoppers buying slightly fewer packs as the economic climate may have led some occasional buyers to question the need to purchase.

The grocery multiples have had some heavyweight three-for-two promotions that have seen their share grow considerably, particularly Tesco, which is firmly in third place (see Top VMS retailers on p22).

Despite the trade activity, the total VMS market has actually seen over a million fewer shoppers than last year and this must stabilise to ensure future growth.

Those still shopping the category have actually increased their total spend to nearly £20 each, so it is an important category for both the pharmacy and grocery trades.

Within the VMS subcategories, herbal products have performed well, along with adult multivitamins.

Traditional cod liver oils and children's products have had a tougher year. Despite this, brands that have performed well include Multibionta from Seven Seas, Bassetts, Berocca and Centrum.

Pharmacy has seen sales of VMS grow 2 per cent year on year to £141m, partly due to Boots. The pharmacies outside of Boots have also seen growth, despite the UK market value falling. They have performed well within herbals, adult multivitamins and the more specialised minerals and supplements area; for example, Litozen, Kwai and Menopace have had a good year within pharmacy.

The minerals and supplements subcategory now accounts for over 24 per cent of total VMS sales in pharmacy. Pharmacy should probably do better within child multivitamins and fish oils.

### Market changes 2008-09

**Total market value**
£398,056,000 DOWN 3%

**Pharmacy**
£140,856,000 UP 2%

### Best-selling VMS brands

**All outlets**

1. Seven Seas other
2. Seven Seas cod liver oil
3. Seven Seas Multibionta
4. Bassetts
5. Haliborange
6. Eye Q
7. Berocca
8. Sanatogen
9. Centrum
10. Litozen

See www.chemistanddruggist.co.uk/indepth for best-selling VMS brands in pharmacy

KANTAR WORLDPANEL

Source: Kantar Worldpanel, year to August 9, 2009
Analysis provided for C+D by Kantar Worldpanel

# CATEGORY FOCUS VMS

The VMS market may be declining, but pharmacy's share is on the increase. **Emma Wilkinson** reveals how pharmacists can boost the upward trend

In recent years the vitamins, minerals and supplements (VMS) market has been growing at a slow but steady 1 to 2 per cent, according to a report published by market researcher MBD six months ago that concluded sales increases reflected an increasingly health conscious UK population.

However, the credit crunch is thought to be the key reason why, in the past year, the value of the VMS market fell by £12 million to £398m – driven by a drop in the volume of sales.

It is not all doom and gloom, however, and analysts expect the market to pick up slightly in 2010, returning to marginal growth of up to 1 per cent a year over the next few years. MBD also expects an ageing population to increase demand for VMS products, with the fish oil market in particular expected to grow by 6 per cent by 2013.

## Pharmacy's fortunes

But with the grocery multiples having a large share of the market, due to three-for-two offers and cheap own-brand multivitamin products popular with consumers, it may seem that pharmacists will struggle to compete.

Data from Euromonitor indicates that pharmacy sales account for less than 16 per cent of the VMS market. Yet those behind leading VMS products maintain that pharmacy offers an important added-value service and has much to offer in terms of boosting sales.

Mark Brewer is brand manager of Vital Life, the UK distributor of the Nordic Naturals range of omega 3 products launched four months ago. He says part of their aim is to improve consumer understanding. "In the current economic climate, consumers are being much more cautious with their spending and are making more informed selections," Mr Brewer explains.

"In the case of Nordic Naturals, we have made a substantial investment in in-store training to maximise sales."

And Nick Mead, sales director for Lifeplan, says repackaging has helped boost sales despite the tightening of the economy last year. "The Lifeplan Goldenhills Manuka Honey range has, within the pharmacy sector, experienced significant and continued distribution increases, with monthly sales reports highlighting healthy repeat orders," he says.

"The introduction of new products continued to increase our product portfolio during 2009 and this year will be no different, as we bring other top quality supplements to market such as our acidophilus and acai berry."

## Pharmacist advice

Elizabeth Denny, brand manager at Pharmaton, advises pharmacists to be clear on the evidence behind products so they relay that when customers ask for advice. She also suggests they be proactive in asking patients what their particular health concerns are, be it stress, tiredness or aching joints.

"Are they simply looking for an all round vitamin supplement, or one that will address a specific concern?" Ms Denny asks. "Also, pay attention to the visible signs – are they a mother with small children, or a harangued-looking business executive?"

Routine chats about coughs and colds or smoking cessation can also be good opportunities to offer advice about vitamins and supplements, she adds. "Ensure your pharmacy assistants are well trained, knowledgeable about the products and are familiar with the benefits of each brand. It's essential that customers feel that they are being recommended the right VMS for them, not just whichever VMS is on special offer that day."

Lynne Henshaw, OTC marketing controller at Numark, agrees that pharmacists often make the mistake of waiting until a patient asks about vitamins or supplements rather than initiating the chat. "If, for example, you have a customer who comes in with recurring mouth sores, cracked lips or split nails, we would often simply sell them a skincare remedy," Ms Henshaw says.

"However, by asking simple questions as to what their diet is like, we could discover that they have a vitamin B2 deficiency, thus making our advice much more valuable.

"By offering advice on diet and thereafter supplements that may be required, we are offering our customers so much more than our supermarket competition ever could."

There are many areas in which a pharmacist's general interest in consumers' health could discover the need for a supplement, Ms Henshaw suggests. For example:

- smokers may be deficient in vitamin C, D and calcium
- older people may benefit from glucosamine for better joint mobility ►►

## VMS sales tips

- **Know the market** The VMS category is broad and customers will need help finding the right product for them.
- **Understand the evidence** You should be able to answer customer questions on individual products.
- **Aid navigation** Consider merchandising VMS according to complaint or target area, eg healthy heart, stress.
- **Be proactive** Consider whether customers could benefit from a VMS product when customers present with complaints such as fatigue, joint pain, coughs and colds.
- **Look out for key customers** Those for whom dietary supplements may be important – such as smokers, the elderly, vegetarians and expectant mothers.
- **Children are choosy** So offer parents a range of flavours and formats.
- **Keep up to date** It is important to be familiar with new products.

**£400m**
VMS total market value

**35%**
Pharmacy market share of VMS

**22%**
Of pharmacy VMS sales are adult multivitamins

Source: Kantar Worldpanel, year to August 9, 2009

## Brand Watch: Bassetts

Launched in 1995 with orange-flavoured pastilles containing 100 per cent RDA of vitamins A, C, D and E, the Bassetts Soft & Chewy brand has grown through new additions and awareness driven by television advertising.

Originally aimed at children, in September 2008 the brand was relaunched with new pack designs and products in order to appeal to a wider audience.

A six-week television campaign launched over Christmas outlines the range of easy to understand one-a-day vitamin products for children and adults. This is supported by a dedicated website, www.bassettsvitamins.co.uk, and a Google advertising campaign.

Now the fourth largest brand in the vitamins market, Bassetts, traditionally better known for sweets, claims it has grown by 11 per cent in the latest month and the last quarter while value share has been growing consistently since May 2009.

The most recent addition to the range, in September, was the Daily Energiser – aimed at young working women who lead busy and hectic lifestyles – containing CoQ10 and a selection of B vitamins.

Daily Energiser was supported by a marketing campaign in the run up to the end of 2009, including London Underground advertising; a sampling programme in London train stations and offices, and online through fashion retailer Asos; and a new website, www.dailyenergiser.co.uk

More category focus articles online
www.chemistanddruggist.co.uk/indepth

- vegetarians may be lacking iron, zinc and B vitamins in their diet
- some prescription medications, such as antidepressants and oral contraceptives, can deplete the body's store of vitamin C, and statins deplete CoQ10.

"There is no substitute for a healthy, balanced diet, but when this is not happening, pharmacists and their staff are ideally placed to give the best advice on supplements," Ms Henshaw concludes. "Make this a category your staff are trained in."

## Mapping the market

Part of the pharmacist's role, and where they have the advantage over supermarkets, is in helping the customer pick the product that is right for them from the dizzying array available.

Boots pharmacist Angela Chalmers says the choice can often be daunting. "We can also make sure that customers are not taking too many supplements at the same time by helping them to rationalise with what they actually need," she says.

"There are lots of different pack sizes and so the pharmacist can help customers choose good value options." Ms Chalmers adds that customers often ask questions about what products are safe to take together and alongside prescribed medicines, and that it is the role of the pharmacist to make sure they are not taking excessive amounts.

Another key area is pregnancy supplements, Ms Chalmers says. "I have actually referred a number of pregnant women to their GP because I suspected they were anaemic. Often this is the case because they come back with a prescription for an iron supplement.

"The bare minimum would be a folic acid supplement, but you may want to recommend a multivitamin supplement if their diet is poor."

Figures provided by Kantar Worldpanel (formerly TNS Worldpanel) for C+D (see Market Insight on p20) found a 10 per cent drop in childhood vitamin sales and point out that pharmacists should probably do better within child multivitamins and fish oils. This is especially true as parents are likely to approach the pharmacist for advice if they are worried about their child's appetite or if they get lots of colds and ear infections.

But in general Ms Chalmers says vitamins – and new products – can be big news. "Often when something new comes on the market, the customers hear about it first and come flooding in asking for the product.

"Pharmacists need to keep up to date with new products so they can give advice to their customers."

## Top VMS retailers

1. Boots
2. Holland & Barrett
3. Tesco
4. Sainsbury
5. Asda
6. Superdrug
7. Morrisons
8. Other chemists
9. Wilkinsons
10. Lloydspharmacy

KANTAR WORLDPANEL

Source: Kantar Worldpanel, year to August 9, 2009

# Case study


ROWLANDS PHARMACY

Rowlands Pharmacy is zoning in on the public demand for health boosting products in their current store redesign, says marketing manager Mike Johnson. The scheme will colour code shelves by the type of therapy on offer, with the green zones denoting those products designed to help customers lead a healthier lifestyle and to aid choice.

"Whilst the VMS market in general is showing a decline year on year, we believe there are still opportunities in the lifestyle and wellbeing vitamins," Mr Johnson says. "For example, instead of vitamin C or D or multivitamins, vitamins [are] actually aimed and named for specific areas like healthy heart, stress, skin, etc; this is where we see future opportunities.

"Our own brand range has been holding its own but sales have been falling in some of the more traditional vitamin ranges with better performance in the more niche premium ranges."

He adds: "Increased public awareness of the health benefits of fresh fruit and vegetables, due in part to the government's Change4Life campaign, has contributed to people looking for more natural sources of vitamins rather than supplements.

"Of course, in a recession, vitamins as discretionary spend will always be one of the first areas to suffer from cutbacks."

Extra data on VMS market changes in 2008-09 is online

www.chemistanddruggist.co.uk/indepth

# Product Watch


**Format:** capsules (30/60/100)
**Pip code:** 021-6523/262-3494/314-8673
**RRP:** £8.99/£15.99/£21.99

## Pharmaton capsules

**Manufacturer:** Boehringer Ingelheim
**Classification:** GSL
**For:** relief of daily fatigue
**Active ingredients:** unique extract G115, from Panax ginseng, plus vitamins A, B, C and D, calcium and folic acid
**USP:** ten clinical trials have demonstrated treatment can reduce tiredness and improve physical and mental performance
**Contraindications:** in patients with disturbances of calcium, hypervitaminosis A or D, renal insufficiency, concomitant retinoid or vitamin D therapy, haemochromatosis, iron overload syndrome and in patients with known hypersensitivity to any of the ingredients. Contains peanut oil
**Tel: 01344 741160**
**www.pharmaton.co.uk**


**Format:** tablets (60)
**Pip code:** 282-9018
**RRP:** £10.55

## ICaps

**Manufacturer:** Alcon Laboratories
**Classification:** GSL
**For:** maintaining healthy eyes
**Active ingredients:** lutein/zeaxanthin, vitamin A, vitamin C, vitamin B2, zinc, selenium, copper, manganese
**USP:** recent research (GfK Healthcare, November 2009) shows ICaps is UK ophthalmologists' first choice ocular supplement. A consumer PR campaign will support ICaps throughout 2010, with activity focusing on women's magazines
**Contraindications:** not recommended for children or in pregnancy
**Tel: 01344 741160**
**Email: gb.visioncare@alconlabs.com**
**www.icapsinfo.co.uk**

C+D AWARDS 2010

In association with NPA National Pharmacy Association

# MUR master

**Jennifer Richardson** finds out how C+D's 2009 MUR Champion of the Year made the service a success

Justin Gilbody has turned MURs into a comprehensive health consultation, including blood pressure tests, weight management advice, BMI checks, stop smoking guidance, alcohol information and other lifestyle advice.

By overcoming initial resistance and getting GPs onside, he secured support to spend one day a week as a 'surgery support pharmacist', with half the funding coming from the PCT and half from the local surgery itself.

This role includes reviewing hospital discharge letters and auditing emergency medication and prescribing. From there, the GPs have given Mr Gilbody the freedom to enter recommendations from his MURs into the surgery system. And his MURs have contributed to reducing the surgery's prescribing budget by up to £4,000 a month; saved it over 30 nurse and GP appointments a month; and earned it QoF points. "It's quality clinical work, and it's saving them money," he says.

One patient who had been prescribed sumatriptan was still complaining of migraines. Through an MUR, Mr Gilbody discovered she was avoiding taking the tablets when she felt the onset of an attack early in the month, as she was worried she would not have sufficient tablets for a worse attack later in the month. His recommendations led to her prescription being increased.

Another patient was referred to hospital after Mr Gilbody became concerned about his breathing problems, and ended up having a heart valve replacement. He has also recommended warfarin initiation, carried out blood pressure checks to save nurse appointments, and a single pain relief discussion with one patient saved the surgery £114 a year.

Mr Gilbody was "very pleased" to win a C+D Award for work he is rightly proud of, though he was unable to attend the celebratory event last June due to the impending birth of his first child. He has had great feedback, he says, from the GPs and customers, following coverage of his win in the local media. The trophy is now proudly displayed in the dispensary. "I don't brag about it," he says, but he adds: "I do show the customers."

But Mr Gilbody also insists that the award was a team effort. Having two ACTs allows him the time to carry out the MURs, he says, and the whole pharmacy team is primed to highlight MURs on each patient's repeat prescription review date. "It's my name on the award, but we won it," Mr Gilbody says. "They all supported me. If you haven't got that you're fighting a losing battle."

Entry for the **2010 C+D MUR Champion of the Year Award** category is now open. Go to **www.chemistanddruggist.co.uk/awards** for full entry details, hints and tips, to download an entry form or enter online.

**Name**
Justin Gilbody

**Pharmacy**
Co-operative Pharmacy, Tibshelf, Derbyshire

**Award won**
C+D MUR Champion of the Year 2009

**Award entry**
Developed MURs into a comprehensive consultation, working with the local surgery

**Football team**
Nottingham Forest "all the way! But I married into the world's biggest Arsenal fans so they're my second team, I've adopted them"

**Last supper**
American diner-style chain Damon's

**Not-so-secret other life**
Mr Gildbody is a one-man tribute act to Freddie Mercury, performing in venues around the UK (see and hear for yourself at www.akindamagic.co.uk)

## How Justin won the C+D MUR Champion of the Year Award 2009

Mr Gilbody has 10 commandments for building an award-winning service:

**1. Aim high** Mr Gilbody was inspired by his MUR accreditation course to make his reviews as clinical as possible. "I have never been able to allow myself to claim £28 from the government just for asking, 'Are you taking the medicines?'."

**2. Stick to your guns** Mr Gilbody says others, including a local PCT, tried to convince him to keep MURs simple. But he refused to downgrade his vision of what he wanted his service to be.

**3. Get your local GPs onside** It's been said before, but Mr Gilbody's more than willing to say it again. He describes as "ridiculous" the attitude of doctors who believe they can't learn anything from a pharmacist intervention. His response? "I didn't get my degree off a Weetabix packet!"

**4. Swallow your pride** Despite clearly not being afraid of confrontation, Mr Gilbody also knows when to go cap in hand and advises simply asking local GPs what they would like to get out of your service. "To overcome [GP resistance] I bent over backwards," he says. "You have to run around after them because they have all the power."

**5. Become part of the community** Mr Gilbody had a headstart, having lived in his pharmacy's area for 15 years, but he has embraced community life and is a local councillor. Being part of the community helps create trust with patients, Mr Gilbody believes.

**6. Put quality above quantity** Mr Gilbody says that targets can mean pharmacists are often torn "between doing professional MURs and being a number checker". He says: "I do worry about numbers because I like to do my job properly, but I won't do it at the expense of quality."

**7. Treat your patients, and your service, with respect** Mr Gilbody believes a pharmacist should not be interrupted while carrying out an MUR, in the same way a GP consultation would not be disturbed. "I'd never dream of interrupting a doctor," says Mr Gilbody. "It's not fair for the person you're reviewing to be interrupted all the time."

**8. Give a little** Mr Gilbody spends some of his own time catching up on his MUR service, for which he is not paid. "There are personal benefits," he says. "The job satisfaction pays for it."

**9. Believe in yourself** "I'm confident in everything I do," says Mr Gilbody, "that's the key. I see a lot of good pharmacists, locums, who're good at what they do but they just lack confidence. It's all about selling yourself."

**10. Appreciate what you've got** Despite his confidence and straight-talking approach, Mr Gilbody emphasises that he would not have had the success he has without support. He says: "I'm lucky that I've got good doctors, good staff, good customers and, if I need any help, I've got good people to call on above me."

Have you experienced something similar? How did you resolve it? Email C+D at haveyoursay@chemistanddruggist.co.uk

## ETHICAL DILEMMA

This series aims to help you make the right decisions when confronted by an ethical dilemma. In the last issue of every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **haveyoursay@chemistanddruggist.co.uk**

# What should you do if a colleague makes an error?

### The dilemma

**You notice your job share pharmacist colleague has made a couple of dispensing errors. Are you legally required to notify your manager and record them or should you just have a quiet word with your colleague? If you choose the latter option, what liabilities might you face if your colleague makes more mistakes?**

If we could all say we were perfect and have never made a mistake then this scenario would not be a dilemma, but most of us make mistakes at some point so will be sympathetic towards colleagues who have done the same. The seriousness of the situation will probably depend, initially at least, on whether the patient took any wrong medication or potentially could have done so, thus putting them at risk of harm. Dispensing mistakes identified during the checking process can be rectified immediately and so the patient is protected from any serious mishap, potential or otherwise.

All pharmacists should have the care of the patient as their first concern and will be using standard operating procedures that should require errors and near misses to be recorded and reported to the responsible pharmacist and for procedures to be reviewed as appropriate.

In the above situation I would record an internal error at the checking phase, pointing it out to the colleague and discussing ways of avoiding a similar error. The only way we can learn from our mistakes is to look at them in a professional manner and make sure we change our way of working if necessary. If the patient brought the mistake to my attention I would also record the error and report it to the superintendent pharmacist or line manager as appropriate.

We not only have a duty of care to our patients but also to our colleagues. Allowing the situation to continue is not an option: I would be failing my colleague. People may be unaware of their mistakes, perhaps because of a lack of knowledge or suitable training, or they may have a personal problem that causes them to lose concentration when they should be focusing on the dispensing/checking process. If the situation continued I would have no choice but to discuss it with my line manager, as the patient's safety is paramount and I would not want other members of staff to be held accountable for my colleague's mistakes. If I were the responsible pharmacist I would be both legally and ethically responsible for any harm to a patient and also for my colleague, whom I would have seriously let down.

**Valerie Sillito is an independent prescriber working in the community for Alliance Boots in Aberdeen.**

### What does the law say?

Key principle seven of the Code of Ethics requires pharmacists to "take responsibility for your working practices". This includes (7.9) an obligation to "raise concerns if policies, systems, working conditions, or the actions, professional performance or health of others may compromise patient care or public safety. Take appropriate action if something goes wrong or if others report concerns to you".

Pharmacists therefore have an obligation to raise concerns about a colleague's poor practice, because this may help to prevent future errors. Failure to do so may result in the Society investigating both the pharmacist who made the error as well as the pharmacist who failed to bring it to the attention of a relevant person.

In the past the Society's Disciplinary Committee has considered that a superintendent pharmacist's failure to take "sufficient" action when presented with several reports of dispensing errors by one particular pharmacist over a relatively long period could amount to misconduct that impaired the superintendent's fitness to practise.

The Society has issued guidance on when and to whom it may be appropriate to raise concerns (Raising Concerns – Guidance for Pharmacists and Pharmacy Technicians – August 2007).

So in this scenario it would probably be appropriate for the pharmacist to raise concerns with the pharmacy owner (or superintendent pharmacist/responsible pharmacist), at the very least by recording the errors in the pharmacy's error log, but I would advise the pharmacist to consider the Society's guidance first.

The Public Interest Disclosure Act 1999 protects whistleblowers provided certain criteria are met so the pharmacist should not suffer any adverse consequences for reporting concerns.

**Noel Wardle is a solicitor at Charles Russell LLP, specialists in pharmacy law.**

**This article can help in the following CPD competencies: G1g, G1h, G1k, G2a, G2i, G4a, G5h, G7c. See http://tinyurl.com/68ox7b**

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**Next month's Ethical Dilemma**
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# Postscript...

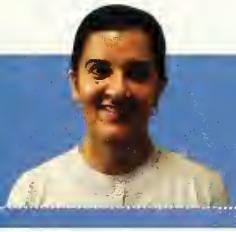
## One hundred years of service


Congratulations to Fishers Pharmacy in south London, which celebrates its 100th birthday this year. The pharmacy actually opened its doors in 1904, but after six years George Fisher bought the business, renaming it Fishers Chemist. A century later and Fishers is still going strong, with 30 staff offering services from MURs to chlamydia testing and a warfarin clinic.

Current owner Alan Kurtz, who took over the premises in 1966, told Postscript it was impossible to explain how pharmacy practice has evolved over the years. "Pharmacy medicines have changed unbelievably, there is no comparison," he said. "We used to be told not to put drug names on labels, or to discuss it with the patient... but the biggest difference is, you no longer make things."

However, Postscript has learned some things at Fishers haven't changed. Inside the shop is one of the premises' original carboys, which has contained a mysterious red liquid since 1910. Postscript can't help but wonder what kind of wondrous ingredient is still lingering inside.

Celebrating an anniversary this year? Let us know: **postscript@chemistanddruggist.co.uk**



## C+D Reader of the week

**Meet Samiah Tambra of Midcounties Co-operative Pharmacy, Pennfields, and discover why she watches action movies to unwind**

**Where is the future of retail pharmacy going?** I think we're getting a closer relationship with other healthcare professionals. And I hope they'll see our strengths. When we have to prove ourselves, we can – we've proved that with MURs.

**What's the best thing about your day?** That it's never the same, there's always something different. Also the staff. We're all on the same wavelength, and go out socially as well as for work.

**What do you like about C+D?** You get a lot of information about different things. C+D is good at letting people know what's going on and keeping you up to date, and also for CPD. At the end of the day, everything you need is in one place.

**How do you relax?** Aerobics and the cinema. I like everything from action movies to weepy films. When you've got three brothers and you're outnumbered, you've got to like action movies!

**Where did you go on your last holiday?** I went to Niagara Falls and Toronto. It was 90° and the hottest summer they'd had in a while.

**What's your favourite joke?** I don't have one really – I laugh at just about anything!

**What one thing about your pharmacy would you change?** A bigger consultation room, maybe. But to be honest there's not much, as we just had a refit.

**What should we ask the next interviewee?** Who is your favourite music group at the moment, and what do you listen to on your way to work?

**Calling all pharmacists and technicians. We want you to be our reader of the week. Email us at postscript@chemistanddruggist.co.uk**

## Web Hunter

Hmm, The Web Hunter. It's a nom de plume that can have several connotations, from a poor rip-off of Stan Lee's Spiderman to someone who collects spider webs, or perhaps just gathers dust.

Still, in this context Web Hunter – as you may have guessed – refers to the worldwide variety. What I hope to bring you in this column is an insight into how the web is changing everything and what the changes could mean to pharmacists.

Take this swine flu panpanic... sorry, pandemic. I have a gorgeous 15-month-old daughter who caught a cold at the height of the media furore surrounding H1N1. My better half was in a tiz, and (half) rightly so. Despite working on a medical title for GPs at the time and hearing the truth (a word I seldom trust) about swine flu – ie that it is a mild, yet virulent virus – I couldn't talk reason into her that our firstborn was in little danger.

So to try to dampen the wildfires of panic I looked up everything I could on swine flu. If you search Google you get literally millions of results, but I ended up on the NHS Direct website. Now the scary thing is, I knew my daughter just had a cold, but after filling in an online questionnaire I was issued with a prescription for Tamiflu.

I'm not sure if you see where I'm going with this yet. Picture a world where a patient can use a website like NHS Direct to get a prescription (albeit repeat) for insulin, statins, warfarin or any number of drugs simply by answering correctly a series of questions online.

Now combine this with the idea of remote supervision and a pharmacist not actually being at the point of dispensing and you are in a pretty scary world. But like I said, I know little about the world of pharmacy. One day, neither might you.

**Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com**

## Online with C+D

### Talking points

**"It's just the usual mess, I'd move to France if I could speak fluent French. Pharmacy is still pharmacy over there"**
Raymond Baker on the delay to the GPhC launch. Posted on C+D online.

### The top stories last week

1. GPhC launch delayed as fears surface over search powers
2. Thief poses as pharmacy worker
3. Update module 1509: Guide to stoma care

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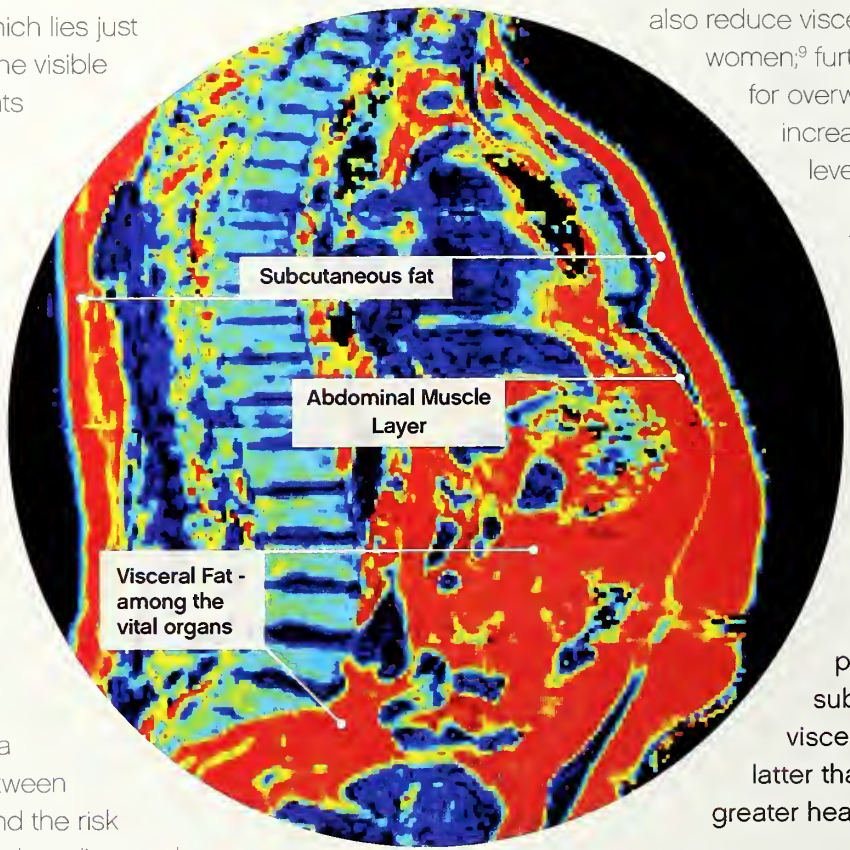
# visceral fat loss – at the centre of weight loss and health gain?

## Targeting "hidden" fat should be an important weight loss goal for those at risk of obesity-related health problems.

Subcutaneous fat, which lies just beneath the skin, is the visible fat that everyone wants to lose. But research focuses our attention on a much more dangerous kind of fat: the visceral fat surrounding the organs in the chest and abdomen.[1-3]




Visceral fat cells produce many chemical messengers that affect metabolic and circulatory pathways.[4,5] There is a clear relationship between excess visceral fat and the risk of type 2 diabetes and cardiovascular disease.[1-3]

The good news is that losing weight with a reduced calorie, lower-fat diet – with or without the help of **alli**, a weight loss aid for overweight adults with a BMI ≥ 28 kg/m$^2$ – can reduce visceral fat mass.[6-8] Studies show that exercise alone can also reduce visceral fat in men[8] and women;[9] further encouragement for overweight people to increase their activity levels.

This knowledge can help pharmacy professionals advise and motivate their customers on the importance of a healthy lifestyle. **The important message is this: weight loss helps people lose both subcutaneous and visceral fat, but it is the latter that brings significantly greater health benefits.**[10]

GSK has examined the effect of the combination of **alli** and a reduced calorie, lower-fat diet in visceral fat loss. The results are soon to be published, so watch this space.

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**References 1.** Larsson B *et al. Br Med J* 1984; **288**: 1401-1404. **2** Yusuf S, *et al. Lancet* 2004; **364**: 937-52. **3**. Wang Y *et al. Am J Clin Nutr* 2005; **81**: 555-63. **4**. Kershaw E *et al. J Clin Endocrinol Metab* 2004; **89**: 2548–2556. **5** Chandran M *et al. Diabetes Care* 2003; **26**: 2442–2450. **6** Purnell J *et al. J Clin Endocrinol Metab* 2000; **85**: 977–82. **7** Goodpaster B *et al. Diabetes* 1999; **48**: 839-47. **8**. Ross R *et al. Ann Intern Med* 2000; **133**: 92-103. **9** Ross A *et al. Obesity Research* 2004, 12: 789–798. **10**. Park HS, Lee K. *Diabetic Med* 2004; **22**: 266-72.